TEXT OF PROPOSED REGULATIONS

CLAIMS SETTLEMENT PRACTICES AND

DISPUTE RESOLUTION MECHANISMS

1. Adopt Section 1300.71, California Code of Regulations (CCR) title 28, to read:

1300.71. Claims Settlement Practices

(a) Definitions.

(1) "Automatically" means the payment of the interest due to the provider within five (5) working days of the payment of the claim without the need for any reminder or request by the provider.

(2) "Complete claim" means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides "information necessary to determine payor liability" and complies with one or more of the following provisions:

(A) For emergency services and care provider claims as defined by Section 1371.35(j):

(i) the information specified in Health and Safety Code Section 1371.35(c); and

(ii) any state-designated data requirements included in statutes or regulations;

(B) For institutional providers:

(i) the completed UB 92 data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC;

(ii) entries stated as mandatory by NUBC and required by federal statute and regulations; and

(iii) any state-designated data requirements included in statutes or regulations;

(C) For dentists:

(i) the form and data set approved by the American Dental Association; and

(ii) any state-designated data requirements included in statutes or regulations;

(D) For physicians and other professional providers generally:

(i) the Centers for Medicare and Medicaid Services (CMS) Form 1500 or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format;

(ii) Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD-9CM) codes;

(iii) entries stated as mandatory by NUCC and required by federal statute and regulations; and

(iv) any state-designated data requirements included in statutes or regulations;

(E) For pharmacists:

(i) a universal claim form and data set approved by the National Council on Prescription Drug Programs; and

(ii) any state-designated data requirements included in statutes or regulations; and

(F) For providers not otherwise specified:

(i) A properly completed paper or electronic billing instrument containing information necessary to determine payor liability for payment of health care expenses, submitted in accordance with the plan's reasonable specifications; and

(ii) any state-designated data requirements included in statutes or regulations.

(3) "Date of contest," "date of denial" or "date of notice" means the date of postmark or electronic mark accurately setting forth the date when the contest, denial or notice was electronically transmitted or deposited in the U.S. Mail or another mail service, correctly addressed and properly mailed with any postage prepaid, to the claimant, however, that this shall not affect the presumption of receipt of mail set forth in Evidence Code section 641.

(4) "Date of payment" means the working day when the payment, by physical or electronic means, is first delivered to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the date of payment, the Department may consider, when auditing a plan's claims payment compliance, the date the check is printed and date the check is cashed.

(5) "Date of receipt" means the working day when the claim, by physical or electronic means, is first delivered to the plan's claims payment office, post office box, or designated claims processor; however, this shall not affect the presumption of receipt of mail set forth in Evidence Code section 641. In the situation where a claim is incorrectly sent to the plan, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the plan's capitated provider or contracted claims processing organization consistent with subsection (b)(2).

(6) "Date of Service" means:

(A) For emergency services and care and all other outpatient services, the date upon which the provider delivered separately billable health care services to the enrollee;

(B) For inpatient services, the date the enrollee was discharged from the inpatient facility.

(7) "Demonstrable and unjust payment pattern" of a plan shall include, but not be limited to, any violation of Health and Safety Code sections 1371, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, or 1371.4 or sections 1300.71, 1300.71.38, 1300.71.4, or 1300.77.4 of title 28 that the Director, in his discretion, deems to be of significance. In making a determination the Director may consider the amount of any claim(s) in question; the timeframe over which non-compliance occurred; the number of alleged occurrences; the potential impact of the practice(s) on the delivery of health care; the plan's intentions or knowledge of the violation(s); the speed and effectiveness of appropriate remedial measures implemented to ameliorate harm to providers or patients, or to preclude future violations; and any previous enforcement actions against the plan.

(8) "Health Maintenance Organization" or "HMO" means a full service health care service plan that maintains a line of business which provides all of the basic health care services described in Health and Safety Code section 1345(b) and section 1300.67 and which, except for emergency or urgent services (or services pursuant to a point-of-service product subject to Health and Safety Code section 1349 and in compliance with Health and Safety Code sections 1374.60 through 1374.71) arranges or pays for health care services for enrollees secured only from participating (contracted or employed) providers as described in Health and Safety Code section 1345(i).

(9) "Information necessary to determine payor liability" or "reasonable relevant information" means the minimum amount of itemized, accurate and material information related to the billed services that are reasonably within the ability of the claiming provider to secure that enables a reasonable person with appropriate training, experience, and competence in timely and accurate claims processing, to determine the nature and

extent of the plan's liability, if any, and to comply with any governmental information requirements;

(10) "Medical records in the control of provider" means medical records generated by or in the possession of the provider pertaining to the particular patient.

Medical records shall be presumed unnecessary to determine payor liability more frequently than in three percent (3%) of the claims submitted to the plan (or the plan's capitated provider or contracted claims processing organization) by any particular class of provider (for example, hospital, skilled nursing facility, physician of any particular specialty, or other separately licensed provider).

(11) "Working days" means Monday through Friday, excluding recognized federal holidays.

(b) Claim Filing Deadline.

(1) No plan (or plan capitated provider or contracted claims processing organization) shall impose a deadline for receipt of claims that is less than 150 calendar days after the date of service, except as required by any state or federal law or regulation.

(2) A plan who has contracted with a claims processing organization or who has delegated claims payment responsibilities to a capitated provider shall forward to the appropriate contracted claims processing organization or capitated provider within five (5) working days of receipt a claim incorrectly sent to the plan.

(3) If a plan is not the primary payor under coordination of benefits, the period for submitting supplemental or coordination of benefits claims to any secondary payors shall begin on the date of payment or date of notice from the primary payor.

(4) A plan~~, which~~ *that* denies a claim because it was filed beyond the claim filing deadline, shall, upon provider's submission of a provider dispute and a showin*g* of good cause, accept, process, and, if otherwise appropriate, pay the claim.

(c) Time Period for Entering Claims. A plan shall enter into its system each claim submission (whether or not complete), and shall identify and acknowledge electronically the receipt of each claim or provide a means by which each provider may readily confirm receipt of the claim electronically, by phone, website, or another mutually agreeable method of notification:

(1) within two working days of the date of receipt of claims filed electronically with the office designated to receive claims, or

(2) within 15 working days of the date of receipt of paper claims by the office designated to receive claims.

(d) Denying, Adjusting or Contesting a Claim. A plan shall not unreasonably deny, adjust, or contest a claim. For each claim that a plan denies, adjusts or contests, the plan shall provide an accurate and clear explanation of the reasons for the action taken within the timeframes specified in subsections (g) and (h).

(e) Contracts for Claims Payment. A plan may contract for ministerial claims processing services with a claims processing organization or delegate claims payment responsibility to capitated providers subject to the following conditions:

(1) the contract shall obligate the claims processing organization or the capitated provider to process or pay claims for services provided to plan enrollees in accordance with the provisions of Health and Safety Code sections 1371, 1371.2, 1371.22, 1371.35, 1371.36,

1371.37, 1371.38 and 1371.4 and sections 1300.71, 1300.71.38, 1300.71.4, 1300.75.4, and 1300.77.4 of title 28,

(2) the plan, on a quarterly basis, shall verify the claims payment performance of all claims processing organizations and capitated providers;

(3) the plan, on a quarterly basis, shall ensure that each of its claims processing organizations and capitated providers who have been delegated claims payment responsibility have the administrative and financial capacity to meet their contractual obligations;

(4) the plan shall, by May 15, 2003, and not more than forty-five (45) days after the close of each subsequent calendar quarter, submit a quarterly report in an electronic format (to be supplied by the Department) to the Director disclosing the compliance status of each of its claims processing organizations and capitated providers with the provisions of Health and Safety Code sections 1371, 137l.35, and 1371.37 and of sections 1300.71 and 1300.71.38 of title 28; and

(5) the contract shall not relieve the plan of its obligations to comply with sections 1371, 1371.2, 1371.22, 1371.35, 1371.36, 1371.4 and 1371.37 and sections 1300.71, 1300.71.38, 1300.71.4, 1300.75.4 and 1300.77.4 of title 28.

(f) Electronic Communication. Any document, notification, notice, acknowledgment, transaction, payment, or other communication required by this regulation may be transmitted in any electronic form mutually agreeable to the parties.

(g) Time for Reimbursement. A health care service plan, including a specialized health care service plan, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after the

date of receipt of the complete claim by the health care service plan, or if the health care service plan is an HMO, 45 working days after the date of receipt of the complete claim by the health care service plan.

(h) Time for Contesting or Denying Claims. A plan may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after the date of receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after the date of receipt of the claim by the health care service plan. Any claim that is held for additional information shall not extend the time for contesting or denying claims.

(i) Interest on the Late Payment of Claims.

(1) Late payment on a claim for emergency services and care, which is neither contested or denied, shall automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis or interest at the rate of 15 percent per annum for the period of time that the payment is late.

(2) Late payments on all other claims shall automatically include interest at the rate of 15 percent per annum.

(j) Penalty for Failure to Automatically Include the Interest Due on a Late Claim Payment. A plan that fails to automatically include the interest due on a late claim payment shall pay the claimant $10 in addition to the required interest payment.

(k) Late or Frivolous Requests. If a plan fails to provide written notice that a claim has been contested or denied to the claimant within the allowable time period prescribed in subsection (h) or requests information from the claimant in excess of the information

necessary to determine payor liability, but ultimately pays the claim in whole or in part, the computation of interest or imposition of penalty pursuant to subsections (i) and (j) shall begin with the first calendar day after the expiration of the Time for Reimbursement as defined in subsection (g).

(l) Information for Contracting Providers. Within 90 calendar days of the effective date of this regulation (unless the plan confirms in writing that current information is in the provider's possession), initially upon contracting and upon the provider's written request, a plan shall disclose to contracting providers the following information in an electronic format (or in writing, if agreeable to both the contracting provider and the plan):

(1) Directions (including the mailing address, email address and facsimile number) for the electronic transmission (if available), physical delivery, and mailing of claims, all claim submission requirements including attachments and supplemental information and documentation consistent with paragraph (A)(9) above, instructions for confirming the plan's receipt of claims consistent with paragraph (c) above, and a phone number for claims inquiries and filing information;

(2) The identity of the office responsible for receiving and resolving provider disputes;

(3) Directions (including the mailing address, email address and facsimile number) for the electronic transmission (if available), physical delivery, and mailing of provider disputes and all claim dispute requirements, instructions for confirming the plan's receipt of provider disputes and a phone number for provider dispute inquiries and filing information;

(4) Directions for filing substantially similar multiple claims or other provider disputes in a bundle as a single provider dispute that includes a numbering scheme for the individual claim or provider disputes contained in the bundled notice.

(m) Modifications to the Information for Contracting Providers. Plans shall provide a minimum of 30 calendar days prior written notice before instituting any amendments or modifications in the disclosures made pursuant to subsection (l).

(n) Notice to the Department. The plan shall submit a pro forma copy of the plan's "Information to Contracting Providers" and "Modification to the Information for Contracting Providers" to the Department of Managed Health Care.

(o) Fee Schedules and Other Required Information. Within 90 calendar days of the effective date of this regulation (unless the plan confirms in writing that current information is in the provider's possession), initially upon contracting, upon the provider's written request and annually thereafter on or before the contract anniversary date, a plan shall disclose to contracting providers the following information in an electronic format (or in writing, if agreeable to both the contracting provider and the plan):

(1) The complete fee schedule for the type of contracting provider(s) consistent with the disclosures specified in section 1300.75.4.1(b) of title 28;

(2) The detailed compensation policies and payment rules used to adjudicate claims, which shall, unless otherwise prohibited by state law:

(A) when available, be consistent with Current Procedural Terminology (CPT) and national Medicare guidelines;

(B) clearly and accurately state what is covered by any global payment provisions for both professional and institutional services, any global payment provisions for all services necessary as part of a course of treatment in an institutional setting, and any other global arrangements such as per diem hospital payments, and

(C) at a minimum, clearly and accurately state the policies regarding: reimbursement for multiple procedures, reimbursement for assistant surgeons, reimbursement for the administration of immunizations and injectible medications, recognition of CPT modifiers, and bundling of CPT codes.

(p) Waiver Prohibited. No plan shall require or allow any provider to waive any right conferred by Health and Safety Code sections 1371, 1371.2, 1371.22, 1371.35, 1371.36, 1371.4 and 1371.37 and sections 1300.71, 1300.71.38, 1300.71.4, 1300.75.4 and 1300.77.4 of title 28, or any obligation of the plan imposed by Health and Safety Code sections 1371, 1371.2, 1371.22, 1371.35, 1371.36, 1371.4 and 1371.37 and sections 1300.71, 1300.71.38, 1300.71.4, 1300.75.4 and 1300.77.4 of title 28, relating to claims processing or payment. Any contractual provision or other agreement purporting to constitute, create, or result in such a waiver is null and void and shall be deemed a demonstrable and unjust payment pattern.

(q) Review and Enforcement. The Department shall periodically review the plan's claims processing system, through periodic medical surveys and financial examinations under Health and Safety Code sections 1380, 1381 or 1382, and when appropriate, through the investigation of complaints of demonstrable and unfair payment patterns. Violations of the Act and this regulation are subject to enforcement action whether or not

remediated, although a plan's self-identification and self-initiated remediation of violations may be considered in determining the appropriate penalty.

Note: Authority cited: Sections 1344, 1346 and 1371.38, Health and Safety Code. Reference cited: Sections 1367, 1370, and 1371.38, Health and Safety Code.

2. Adopt Section 1300.71.38, California Code of Regulations (CCR) title 28, to read:

1300.71.38. Fair, Fast, and Cost-Effective Dispute Resolution Mechanism

All health care service plans shall establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. A plan may maintain separate dispute resolution mechanisms for contracted and non-contracted provider disputes and separate dispute resolution mechanisms for claims and other types of billing and contract disputes, provided that each mechanism complies with Health and Safety Code sections 1367(h), 1371, 1371.2, 1371.22, 1371.35, 1371.36, 1371, 1371.37, 1371.38 and sections 1300.71, 1300.71.38, 1300.71.4, 1300.75.4 and 1300.77.4 of title 28.

(a) Definitions:

(1) "Contracted Provider Dispute" means a contracted provider's written notice to the plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or a bundled group of substantially similar claims that are individually

numbered) containing the following information: the provider's name; provider ID; contact information; and:

(A) If the dispute concerns a claim, a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, or other action is incorrect;

(B) If the dispute is not about a claim, an explanation of the issue; and

(C) If the dispute involves a patient(s), the name and any identification number(s) of the patient(s).

(2) "Non-Contracted Provider Dispute" means a non-contracted provider's written notice to the plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar claims that are individually numbered) that has been denied, adjusted or contested containing the following information:

(A) The provider's name; provider ID; contact information, a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, or other action is incorrect and,

(B) If the dispute involves a patient(s), the name and any identification number(s) of the patient(s);

(3) "Date of receipt" means the working day when the provider dispute or amended provider dispute, by physical or electronic means, is first delivered to the plan's dispute resolution office, or post office box; however, this shall not affect the presumption of receipt of mail set forth in Evidence Code section 641.

(4) "Date of Determination" means the working day when the provider dispute determination or amended provider dispute determination, by physical or electronic

means, is first delivered to the claimant's office or other address of record. To the extent that a postmark or electronic mark is unavailable to confirm the Date of Determination, the Department may consider, when auditing a plan's provider dispute mechanism, the date the check is printed for any monies determined to be due and owing the provider and date the check is cashed.

(b) Notice to Provider of Dispute Resolution Mechanism(s). Whenever a plan contests, adjusts or denies a claim, it shall inform the provider of the availability of the provider dispute resolution mechanism and the procedures for obtaining forms and instructions for filing a provider dispute.

(c) Submission of Provider Disputes. The plan shall establish written procedures for the submission, receipt, processing and resolution of contracted and non-contracted provider disputes that, at a minimum, shall provide that:

(1) Contracted Provider Disputes shall be submitted in a manner consistent with procedures disclosed in section 1300.71(l)(2)-(4) of title 28.

(2) Non-contracted Provider Disputes shall be submitted in a manner consistent with the directions for obtaining forms and instructions for filing a provider dispute attached to the plan's notice that the subject claim has been denied, adjusted or contested or pursuant to the directions for filing Non-contracted Provider Disputes contained on the plan's website.

(3) The plan shall handle any provider dispute submitted on behalf of a patient or a class of patients in the plan's consumer grievance process and may require the consent of the patient, in which case the provider shall be deemed to be joining with or assisting the enrollee within the meaning of Health and Safety Code section 1368.

(d) Time Period for Submission.

(1) A provider dispute for an individual claim, billing dispute or other contractual dispute shall be submitted to the plan within 365 days of the plan action or in the case of inaction, 365 days after the Time for Contesting or Denying Claims has expired. If the dispute relates to an unfair payment practice by the plan, the filing shall be considered timely if it is filed within 365 days of the plan's most recent action or inaction;

(2) The plan may return any provider dispute lacking the information enumerated in either subsections (a)(1) or (a)(2), if the information is not readily accessible to the plan. Along with any returned provider dispute, the plan shall clearly identify the missing information necessary to resolve the dispute consistent with Health and Safety Code section 1300.71(a)(9). The provider may submit an amended provider dispute within thirty (30) working days of the date of receipt of a returned provider dispute setting forth the missing information.

(e) Time Period for Acknowledgment. A plan shall enter into its dispute resolution mechanism system each provider dispute submission (whether or not complete), and shall identify and acknowledge the receipt of each provider dispute:

(1) within two working days of the date of receipt of provider dispute filed electronically with the office designated to receive provider disputes, or

(2) within 15 working days of the date of receipt of a paper provider dispute by the office designated to receive provider disputes.

(f) Time Period for Resolution and Written Determination. The plan shall resolve each provider dispute or amended provider dispute, consistent with the provisions of Health and Safety Code sections 1371 and 1371.35, and of section 1300.71 of title 28,

and issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or amended provider dispute. Copies of provider disputes and plan determinations, including all notes, documents and other information upon which the plan relied to reach its decision, and all reports and related information shall be retained for at least the period specified in section 1300.85.1 of title 28.

(g) Past Due Payments. If the provider dispute or amended provider dispute involving a claim is determined in whole or in part in favor of the provider, the plan shall pay any outstanding monies determined to be due, together with all interest and penalties required under Health and Safety Code sections 1371 or 1371.35, and sections 1300.71, 1300.71.38, and 1300.71.4 of title 28, within 10 working days of the Date of Determination.

(h) Designation of Plan Officer. The plan shall designate a principal officer of the plan, as defined by section 1300.45(o) of title 28, to be primarily responsible for the maintenance of the plan's provider dispute resolution mechanism(s), for the review of its operations, and for noting any emerging patterns of provider disputes to improve the plan's administration, plan-provider relations, and patient care. The designated principal officer shall be responsible for preparing, on a quarterly basis (quarterly internal report), a written, tabulated record of all provider disputes, categorized by date of receipt, identification of the provider, type of dispute, disposition, and working days to resolution, as to each provider dispute received and shall disclose to the Department any emerging patterns of provider disputes. Each dispute contained in a provider's bundled submission

shall be reported separately in the plan's quarterly internal reports and its annual report to the Department pursuant to subsection (m).

(i) No Discrimination. The plan shall take all necessary steps to ensure that there is no discrimination or retaliation against a provider (including cancellation of the provider's contract with the plan) because the provider filed a provider dispute.

(j) Dispute Resolution Costs. A provider dispute directly or indirectly involving the plan or its enrollees shall be received, handled, and resolved by the plan at no cost to the provider; however, a plan shall have no obligation to reimburse a provider for any costs incurred in connection with utilizing the plan's provider dispute resolution mechanism. Arbitration shall not be deemed a provider dispute or a provider dispute resolution mechanism for the purposes of this section.

(k) Delegation of Dispute Resolution Administration. A plan may contract with its claims processing organization or its capitated provider to administer the dispute resolution mechanism relating to their respective claims processing activities, subject to the following conditions:

(1) The plan itself directly receives, reviews, and resolves every provider dispute that expressly requests the plan to do so and does not refer the dispute to the contracted claims processing organization or capitated provider responsible for payment of the claim for review or recommendations, however a plan may request information from the capitated provider or the claims processing organization reasonably necessary to resolve the dispute;

(2) Each provider whose dispute resolution was administered by a claims processing organization or a capitated provider shall have an unconditional right of appeal, for a

period of 60 working days from the Date of Determination, to the plan for de novo review and resolution of the provider dispute, pursuant to the provisions of this section;

(3) The contract between the plan and the claims processing organization or capitated provider responsible to administer the dispute resolution mechanism shall obligate the claims processing organization or capitated provider:

(A) in its receipt, review, and resolution of provider disputes to comply with Health and Safety Code sections 1367(h), 1371, 1371.2, 1371.4, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, and 1375.4, and sections 1300.71, 1300.71.38, 1300.71.4, 1300.75.4 and 1300.77.4 of title 28,

(B) to make available to the plan all records, notes and documents regarding its provider dispute resolution mechanism(s) and the resolution of its provider disputes; and

(C) to submit a quarterly report for each calendar quarter beginning on or after January 1, 2003, not more than forty-five (45) days after the close of the calendar quarter and a complete annual report beginning with the year 2003 and for each subsequent year , not more than 90 days after the end of the calendar year to the plan summarizing the provider organization's review and resolution of each provider dispute, including compliance and related information required for the plan's quarterly internal reports and the plan's Annual Plan Dispute Resolution Mechanism Report to the Department;

(4) The plan remains fully responsible for the timely and proper receipt, review, and resolution of all provider disputes, including those reviewed and resolved by its contracted claims processing organization or the plan's capitated providers; provided, however, that this shall not increase the financial liability of the plan to any provider beyond that otherwise required by provisions of the Act, title 28, or contract;

(5) The plan's "Annual Plan Dispute Resolution Mechanism Report" to the Department is timely submitted and accurately includes all pertinent claims dispute resolution data from all capitated providers and contracted claims processing organizations.

(l) No Waivers: This section shall not be construed as limiting the process of contractual negotiations between a plan and a provider; however, no contract with a provider shall waive or purport to waive any provision of Health and Safety Code sections 1367(h), 1371, 1371.2, 1371.4, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, and 1375.4, and sections 1300.71, 1300.71.38, 1300.71.4, 1300.75.4 and 1300.77.4 of title 28.

(m) Required Reports. Beginning with the year 2003 and for each subsequent year, the plan shall submit to the Department no more than 120 days after the close of the calendar year, an "Annual Plan Dispute Resolution Mechanism Report" on an electronic-form to be supplied by the Department pursuant to section 1300.41.8 of title 28 containing the following:

(1) Information on the number of providers utilizing the dispute resolution mechanism;

(2) A summary of the disposition of all provider disputes, which shall include an informative description of the types, terms, and resolution. Information may be submitted in the aggregate format so long as all data entries are appropriately footnoted to provide full and fair disclosure;

(3) A detailed, informative statement maintained on a current basis, indicating any emerging or established patterns of provider disputes and how that information has been

used to improve the plan's administration, plan-provider relations, quality assurance system (process), and quality of patient care (results). The information provided pursuant to this Subsection shall be submitted with but separately from the other portions of the report and may be accompanied by a cover letter containing a request for confidential treatment pursuant to the section 1007 of title 28; and

(4) Confidentiality. The plan's Annual Plan Dispute Resolution Mechanism Report to the Department regarding its dispute resolution mechanism shall be public information except for information disclosed pursuant to subsection (m)(3) above, that the Director, pursuant to a plan's written request, determines should be maintained on a confidential basis.

(n) Review and Enforcement.

The Department shall periodically review the plan's provider dispute resolution mechanism(s), including the records of provider disputes filed with the plan and remedial action taken pursuant to subsection (m)(3), through periodic medical surveys and financial examinations under Health and Safety Code sections 1380, 1381 or 1382, and when appropriate, through the investigation of complaints of unfair provider dispute resolution mechanism(s). Violations of the Act and this regulation are subject to enforcement action whether or not remediated, although a plan's self-identification and self-initiated remediation of violations may be considered in determining the appropriate penalty.

Note: Authority cited: Sections 1344, 1346 and 1371.38, Health and Safety Code. Reference cited: Sections 1367, 1371, and 1371.38, Health and Safety Code.